FORM No. 01

My Health LA - CLINIC SITE PROFILE

Date Completed:

Agency Name:
(Enter Legal Name Only)

Instructions: Complete For Each Clinic Site *(Click and type in the GRAY HIGHLIGHTED placeholders below)*

Clinic Site Location: **Electronic Health Records**: ☐ Yes ☐ No

Site Name: Phone Number: Fax Number: After Hours Phone Number:

Address: City/State: Zip Code: Email Address:

Language(s) Spoken in the Clinic: English;

Type of Site: ☐ Full-Time Site ☐ Part-Time Site ☐ Satellite Site ☐ Community School ☐ Children's School ☐ Administrative Enrollment

☐ Mobile: License Plate # _____ Services provided: [ ] Single Location - Address [ ] Multiple Locations - Address:

Primary Care Services:

Is this an approved CHDP Site: ☐ No ☐ Yes – (Must attach certification) CHDP Effective Date:

Number of Days of Clinic Operation Per Week: Number of Hours of Clinic Operation Per Week:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours of Operation (e.g. 8:00am to 5:00pm) *(If Mobile – indicate address location)*							

Dental Care Services:

1) Does this Clinic Site provide Dental Services ☐ **No** ☐ **Yes**

Dental Services Provided: ☐ Pediatric Only ☐ Adult Only ☐ Adult and Pediatric

Number of Days of Clinic Operation Per Week: Number of Hours of Clinic Operation Per Week:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours of Operation (e.g. 8:00am to 5:00pm)							

Ancillary Services:

Radiology Services: *(Clinic site must provide basic radiology services that are within the scope of Ancillary Services and operate a radiological unit or establish a formal subcontract agreement with a certified radiological entity.)*

☐ **On-Site - Name:** Days/Hours of Operation:
☐ **Off-Site - Name:** Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

Laboratory Services: *(Clinic must provide all Medically Necessary laboratory services related to Primary Health Care Services and must operate a full service laboratory or establish a formal subcontract agreement with a certified laboratory.)*

☐ **On-Site - Name:** Days/Hours of Operation:
☐ **Off-Site - Name:** Days/Hours of Operation:
Address: City/State: Zip Code: Phone Number:

Pharmacy Services: *(Clinic Site must provide all medically necessary pharmaceuticals related to the conditions for which the Participants are receiving Included Services, and for paying for such pharmaceuticals. Clinic Site must also be registered with HRSA Office of Pharmacy Affairs to access the 340B Drug Pricing Program and register at least one contracted 340B pharmacy to dispense 340B pharmaceuticals to Participants in order to qualify for a MHLA approved site.)*

☐ **HRSA 340B Drug Pricing ID #:** Participating Start Date: Approved Date:

☐ **Do you have at least one HRSA 340B Contract Pharmacy** ☐ **No** ☐ **Yes**

Did you select DHS Central and Rx-E-Fill Pharmacy ☐ **No** ☐ **Yes**

☐ **On-Site Licensed Pharmacy Services - Retail Pharmacy License #:** Expiration Date:
Days/Hours of Operation: Phone Number:

☐ **On-Site Pharmacy Dispensary - Clinic Permit #:** Expiration Date:
Days/Hours of Operation: Phone Number:

☐ **Sub-Contracted Pharmacy Services:** Name of Subcontracted Pharmacy**:** Address:
City/State: Zip Code: Phone Number: Days/Hours of Operation**:**

Form Completed By: Telephone Number: Email: